NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

February 28, 1990

Henry J. Dobies, Physician
173 East Orvis Street
Massena, N.Y. 13362

Re: License No. 076017

Dear Dr. Dobies:

Enclosed please find Commissioner's Order No. 10113. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Anthony Z. Scher, Esq.
The Harwood Building
Suite 512
14 Harwood Court
Scarsdale, N.Y. 10583

REPORT OF THE
REGENTS REVIEW COMMITTEE

J. DOBIES

CALENDAR NO. 10113

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

HENRY J. DOBIES **No. 10113**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

HENRY J. DOBIES, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on July 14, August 18, August 19, October 28, and November 11, 1988 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of the first specification of the charges to the extent indicated in its report, and the seventh specification of the charges, and not guilty of the remaining charges. Paragraphs C(5)(i), C(5)(ii), and C(5)(iii) of the statement of charges were withdrawn at the hearing.

The hearing committee recommended that respondent be Censured and Reprimanded and that the necessary steps be taken so that respondent is hereafter prohibited from engaging in any practice in the field of obstetrics.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted except as indicated in his recommendation, and that the recommendation of the hearing committee be modified as indicated in his recommendation. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On November 2, 1989 respondent appeared before us in person and was represented by his attorney, Anthony Z. Scher, Esq., who presented oral argument on behalf of respondent. Daniel J. Persing, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure

of discipline to be imposed, should respondent be found guilty, was that respondent's license to practice as a physician in the State of New York be suspended so that he is not allowed to practice obstetrics except to take a retraining course in obstetrics of at least six months duration approved in advance by the Office of Professional Medical Conduct. Upon respondent's successful completion of such retraining, as certified by OPMC, the suspension of respondent's license to practice should be continued for three additional years and such suspension stayed provided that during such period respondent's obstetrical practice should be monitored by an obstetrician approved by OPMC. The monitor shall submit quarterly reports to OPMC as to the propriety of respondent's obstetrical practice.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that respondent be Censured and Reprimanded.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's October 17, 1989 memorandum and petitioner's October 23, 1989 memorandum.

We note that the first specification alternatively charged negligence on more than one occasion and incompetence on more than one occasion, rather than separately stating and numbering these charges. The hearing committee did not clearly specifically

conclude whether respondent was guilty of negligence on more than one occasion or of incompetence on more than occasion. However, it appears that the Commissioner of Health assumed that the hearing committee had concluded respondent was guilty of negligence on more than one occasion. This confusion is the result of the manner in which the specifications were drawn. It is suggested that, in the future, a charge of negligence on more than one occasion be a separate specification from a charge of incompetence on more than one occasion and the two specifications should be separately stated and numbered. This would create clarity for all concerned. In any event, based on the hearing committee's findings of fact and conclusions as to paragraphs A(2), A(3), B(1), and B(2) of the charges and the record herein, it is our unanimous opinion that respondent was guilty of negligence on more than one occasion and not guilty of incompetence on more than one occasion.

We also agree with the hearing committee that respondent is guilty of the seventh specification of the charges and not guilty of the remaining charges. With respect to the specific charges A(2), A(3), B(3), B(4), C(4), and B(6)(i) we agree with the conclusions of the hearing committee set forth at pages 8, 9, 10, 12, 13, 14, 15, 16, and 24 of the hearing committee report based upon the following findings of fact: 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 31, 32, 33, 34, 35, 36, 61, 62, 63, and 64.

We also note that we reject respondent's contention that this

case comes under the doctrine of Rho v. Ambach, Slip Op. No. 200 (N.Y. Ct. of Appeals, October 19, 1989). Respondent herein was found guilty of failing to appropriately monitor the fetus after patient A's fortieth week of gestation (prior to August 13, 1984), and of performing on August 13, 1984 an x-ray of patient A's abdomen to determine fetal position, thereby exposing patient A and the fetus to unnecessary radiation. These events occurred prior to patient A being hospitalized on August 29, 1984 for delivery of her baby. Subsequent to patient A's being hospitalized for purposes of delivery, respondent was guilty of failing to recognize the risks associated with patient A's postmature pregnancy, and of failing to arrange for close monitoring of the fetal heart rate. These are, in our opinion, events of some duration occurring at a particular time and place. We do not consider that, because only one patient is involved, Rho mandates that respondent cannot be guilty of negligence on more than one occasion. In our opinion, the events herein which occurred at different periods during the course of patient A's pregnancy constitute separate occasions of negligence and not multiple acts of negligence on a single occasion. At different stages of the pregnancy respondent was found to have committed separate acts of negligence. In our opinion, the differing stages involved in the pregnancy amount to separate occasions.

We unanimously recommend to the Board of Regents that:

HENRY J. DOBIES (10113)

1. The hearing committee's findings of fact be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact be accepted;

2. The hearing committee's conclusions as to the question of respondent's guilt be accepted as hereafter indicated, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted to the extent hereafter indicated;

3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of paragraphs A(2), A(3), B(1), and B(2) under the first specification of the statement of charges as constituting negligence on more than one occasion, and of the seventh specification of the charges, and not guilty of the remaining charges; and

5. In partial agreement with certain aspects of the recommendations of petitioner, respondent, hearing committee, and Commissioner of Health, respondent be Censured and Reprimanded upon each specification of the charges of which we recommend respondent be found guilty, as aforesaid; and respondent be placed on probation for three years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit

"D", which includes, among other things, a provision prohibiting respondent from practicing obstetrics until respondent successfully completes a one year course of training in obstetrics.

In arriving at our recommendation as to the measure of discipline, we have considered the circumstances herein, including but not limited to the misconduct having occurred over five years ago, respondent's good reputation in his community, and respondent having been found guilty of only two of twelve specifications under five out of 22 paragraphs originally charged, three paragraphs having been withdrawn.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 1/25/90

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	STATEMENT
OF	:	OF
HENRY J. DOBIES, M.D.	:	CHARGES

HENRY J. DOBIES, the Respondent, was authorized to engage in the practice of medicine in the State of New York on November 16, 1954 by the issuance of License Number 076017 by the State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 at 173 East Orvis Street, Massena, NY 13662.

FACTUAL ALLEGATIONS

A. From on or about December 12, 1983 through on or about August 30, 1984, Respondent provided care and treatment to Patient A for pregnancy (Patient A's name and all other patients names appear in the attached Appendix) at the Doctors Clinic in Massena, New York. Patient A's expected date of confinement was on or about August 5, 1984.

1. Respondent failed to maintain accurate medical records in that:

(i) Respondent failed to record the date of artificial insemination of Patient A.

(ii) Respondent failed to record the results of Patient A's pelvic exam.

2. Respondent failed to appropriately monitor the fetus after Patient A's fortieth week of gestation.

3. On or about August 13, 1984, Respondent performed an x-ray of Patient A's abdomen to determine fetal position, thereby exposing Patient A and the fetus to unnecessary radiation.

B. On or about August 29, 1984, Patient A was admitted to Massena Memorial Hospital in Massena, New York for labor and delivery.

1. Respondent failed to recognize the risks associated with Patient A's postmature pregnancy.

2. Respondent failed to arrange for close monitoring of the fetal heart rate.

3. Respondent failed to review the fetal monitor strip through the course of Patient A's labor.

4. Respondent prescribed 10 grains quinine on at least two occasions during Patient A's labor despite its contraindication.

5. Respondent failed to diagnose Patient A's arrest of labor.

6. Respondent failed to recognize the emergency of fetal distress in Patient A in that:

(i) Respondent failed to respond to the significance of decreased variability of the fetal heart rate after little variability had been noted upon admission of Patient A.

(ii) Respondent failed to initiate prompt diagnostic measures and appropriate treatment when advised no fetal heart could be heard.

7. Respondent failed to maintain accurate medical records in that:

(i) Respondent's records disclose Patient A's labor as uncomplicated and that "labor progressed well" when in fact the labor had arrested.

(ii) Respondent's records fail to disclose a 10:35 p.m. call made to Respondent advising no fetal heart could be heard.

C. On or about July 5, 1985, Respondent provided care and treatment to Patient B when Patient B was admitted to Massena Memorial Hospital in Massena, New York, for labor and delivery.

1. Respondent failed to record adequately Patient B's labor.

2. Respondent failed to record an adequate medical history in Patient B's hospital record.

3. Respondent failed to recognize the emergency of fetal distress in Patient B in that:

(i) Respondent failed to respond adequately to the lack of fetal heart rate variability during the course of Patient B's labor.

(ii) Respondent failed to respond adequately to patterns of late deceleration of the fetal heart rate during the course of Patient B's labor.

4. Respondent prescribed 10 grains quinine on at least two occasions during Patient B's labor despite its contraindication.

5. Respondent failed to follow the recommendations of a consulting physician, to wit:

(i) Respondent failed to obtain a urinalysis.

(ii) Respondent failed to obtain a complete blood count.

(iii) Respondent failed to conduct a pelvinimetry of Patient B.

(iv) Respondent failed to augment Patient B's contractions with Pitocin.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE AND/OR

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence and/or incompetence on more than one occasion under N.Y. Education Law §6509(2) (McKinney 1985), in that Petitioner charges

1. The facts in Paragraphs A and A.1(i), A and A.1(ii), A and A.2., A and A.3., B and B.1., B and B.2., B and B.3., B and B.4., B and B.5., B and B.6(i), B and B.6(ii), C and C.1., C and C.2., C. and C.3.(i), C and C.3.(ii), C and C.4., C and C.5.(i), C and C.5.(ii), C and C.5.(iii), and/or C and C.5.(iv).

SECOND THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE OR

GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross negligence and/or gross incompetence under N.Y. Education Law §6509(2) (McKinney 1985), in that Petitioner alleges:

2. The facts in Paragraphs A and A.1(i), A and A.1.(ii), A and A.2. and/or A and A.3.

3. The facts in Paragraphs B and B.1., B and B.2., B and B.3., B and B.4., B and B.5., B and B.6.(i) and/or B and B.6.(ii).

4. The facts in Paragraphs C and C.3(i), C and C.3(ii), C and C.4., C and C.5.(i), C and C.5(ii), and C.5.(iii) and/or C and C.5.(iv).

FIFTH AND SIXTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Education Law §6509(2) (McKinney 1985), in that Petitioner charges:

5. The facts in Paragraph B and B.7(i).

6. The facts in Paragraph B and B.7(ii).

SEVENTH THROUGH TWELFTH SPECIFICATIONS

COMMITTING UNPROFESSIONAL CONDUCT

BY FAILING TO MAINTAIN ACCURATE

PATIENT RECORD

Respondent is charged with committing unprofessional conduct under N.Y. Education Law §6509(9) (McKinney 1985) and 8 NYCRR 29.2(a)(3) (1987) by failing to maintain records which accurately reflect the evaluation and treatment of patients, in that Petitioner charges:

7. The facts in Paragraphs A and A.1(i).

8. The facts in Paragraphs A and A.1(ii)

9. The facts in Paragraphs B and B.7(i).

10. The facts in Paragraphs B and B.7(ii).

11. The facts in Paragraphs C and C.1.

12. The facts in Paragraphs C and C.2.

DATED: Albany, New York
June 10, 1988

Peter D Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

HENRY J. DOBIES, M.D.

REPORT OF

HEARING

COMMITTEE

TO: HONORABLE DAVID AXELROD, M.D.
COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK

The undersigned Hearing Committee (the Committee) consisting of John T. Prior, M.D., Chairperson, Reverend Edward J. Hayes and Therese G. Lynch, M.D. was duly designated, constituted and appoint by the State Board for Professional Medical Conduct (the Board). John J. Stewart, Esq. and Marshall Jay Grauer, Esq. served as the Administrative Law Judges.

The hearing was conducted pursuant to the provisions of New York Public Health Law Section 230 and New York State Administrative Procedure Act Sections 301-307 to receive evidence concerning the charges that the Respondent has violated provisions of the New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above-captioned matter and makes a Report of its Findings of Fact, Conclusions and Recommendations to the New York State Commissioner of Health.

EXHIBIT "2"

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	June 10, 1988
Hearing Dates:	July 14, 1988 August 18, 1988 August 19, 1988 October 28, 1988 November 11, 1988
Hearing location:	Airport Inn Syracuse, New York
Date and location of deliberations held by Committee:	December 28, 1988 Airport Inn Syracuse, New York
The State Board for Professional Medical Conduct appeared by:	Daniel J. Persing, Esq. Empire State Plaza 24th Floor Albany, New York 12237
Respondent appeared by:	Wood & Scher Anthony Z. Scher, Esq., Of Counsel One Chase Road Scarsdale, New York 10583
Respondent's Address:	173 East Orvis Street Massena, New York 13662

WITNESSES

FOR THE DEPARTMENT

RITA WEST	Registered nurse formerly employed by Massena Memorial Hospital
SYBILL ANN HARRISON	Registered nurse employed by Massena Memorial Hospital
ELIZABETH LAROSA	Registered nurse employed by Massena Memorial Hospital

HAROLD W. BAUM, M.D.	Licensed physician - Board Certified in obstetrics and gynecology.
BARBARA ANNE GILLAN MILLER (via telephone)	Registered Nurse

FOR THE RESPONDENT

DR. WADE HASTINGS	Physician in general practice
DR. OMER POIRIER	Licensed physician - Board Certified in family practice
DR. DAVID P. GORMAN	Licensed physician - Board Certified in obstetrics and gynecology
DR. JOHN BENTON PIKE	Licensed physician - Board Certified in Family Practice
FLOYD J. BROWN	Catholic Clergyman, Pastor in Louisville, New York
ROBERT L. SCHEER, M.D.	Licensed physician - Board Certified internist and Board Certified nephrologist
HENRY J. DOBIES, M.D.	Respondent

SUMMARY OF CHARGES

Respondent, a duly licensed, practicing physician, is charged with negligence and/or incompetence; gross negligence and/or incompetence; practicing the profession fraudulently and committing unprofessional conduct in connection with his treatment with Patients A and B relative to their prenatal care and/or the delivery of their infants and further with respect to his maintaining and/or failing to maintain accurate patient

records. The Statement of Charges encompasses the period between December 12, 1983 and July 5, 1985.

PRELIMINARY FINDINGS

1. Respondent, Henry J. Dobies, M.D., was authorized to engage in the practice of medicine in New York State on November 16, 1954 by the issuance of license no. 076017 by the New York State Education Department. (Exh. "1")

2. Respondent is registered to practice medicine at 173 East Orvis Street, Massena, New York. (Exh. "A")

3. Respondent is board certified in family practice. (Exh. "A")

FACTUAL ALLEGATIONS

Charge "A1(i)"

A. From on or about December 12, 1983 through on or about August 30, 1984, Respondent provided care and treatment to Patient A for pregnancy at the Doctors Clinic in Massena, New York. Patient A's expected date of confinement was on or about August 5, 1984.

1. Respondent failed to maintain accurate medical records in that:

(i) Respondent failed to record the date of artificial insemination of Patient A.

FINDINGS

1. Respondent provided prenatal care to Patient A, a female patient from on or about December 12, 1983 through on or about August 30, 1984. (Exh. "2") (p. 512-513)

2. Patient A had been artificially inseminated prior to her initial contact with Respondent. (Exh. "2") (p. 513)

3. Patient A provided Respondent with a card which documented her artificial insemination, and Respondent fastened the card to his office records. Said card subsequently became detached and was lost. (p. 513)

4. Respondent did not make any separate entries in Patient A's chart of the date of artificial insemination. (Exh. "2")

CONCLUSIONS

With respect to Charge "A1(i)", the Hearing Committee concludes as follows:

First Specification: (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Second Specification (Gross Negligence or Gross Incompetence) - Not sustained by vote of 3-0.

Seventh Specification (Committing Unprofessional Conduct by Failing to Maintain Accurate Patient Record) - Sustained by vote of 2-1.

Paragraph "A1(i)" is a correct statement of fact in that Respondent did not make an entry in his records of the date of Patient A's artificial insemination but merely attached a small card containing that information to his office records. Said card became detached and, therefore, the office records lacked that information. Although it would have been preferable if the Respondent did make a separate entry in the records of this fact, the Hearing Committee concludes that Respondent's omission did not constitute negligence or incompetence. However, the

Hearing Committee concludes that Respondent is guilty of professional misconduct by failing to maintain accurate records by not making such entries.

FACTUAL ALLEGATIONS
Charge "A1(ii)"

(ii) Respondent failed to record the results of Patient A's pelvic exam.

FINDINGS

5. Respondent performed a pelvic exam on Patient A on December 12, 1983 (Exh. "2")

6. Respondent made entries in the office chart noting, among other things, that Patient A was artificially inseminated, her last menstrual period, estimated date of confinement, weight, blood pressure, the fact that bloodwork was done and that the pelvic exam was negative. (Exh. "2")

7. The size of Patient A's uterus was not recorded. (Exh. "2")

8. Normal findings are frequently not recorded in patient charts. (p. 222)

CONCLUSIONS

With respect to Charge "A1(ii)", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote of 2-1.

Second Specification (Gross Negligence and/or Gross

Incompetence) - Not sustained by vote of 3-0.

Eighth Specification (Unprofessional conduct) - Not sustained by a vote of 2-1.

The Hearing Committee concludes that Respondent conducted a pelvic exam of Patient A on December 12, 1983. Admittedly, Respondent made a rather sparse entry, e.g. "PE-neg", indicating that the pelvic exam was negative and which was intended to record the fact that nothing remarkable was observed. Although Respondent could have made more comprehensive entries relative to the pelvic examination, the Committee concludes there was no negligence, incompetence or unprofessional conduct.

FACTUAL ALLEGATIONS

Charge "A2"

2. Respondent failed to appropriately monitor the fetus after Patient A's fortieth week of gestation.

FINDINGS

9. On August 10, 1984, Patient A was admitted to Massena Memorial Hospital by reason of the fact that "A" could not detect any fetal movement. (Exh. "3")

10. Patient A was placed on a fetal monitor, and it was noted in the patient record by Respondent that heartbeat and variability were good. (Exh. "3" - p. 2)

11. There were signs that the fetus was in trouble since there was no indication of fetal motion on the monitor record, and there was a lack of variability in the fetal heartbeat. (p. 178-179)

12. A nonstress test was performed on August 10, 1984, and thereafter, no tests were performed until August 28, 1984, at which time a sonogram was done. (p. 181) (Exh. "2") (Exh. "5")

13. In a patient over 40 weeks of pregnancy, a nonstress test should be performed two times a week to verify the condition of the fetus. (p. 180-182)

14. Even though the nonstress test performed on August 10, 1984 appeared to show good variability, a patient of 42 weeks should have another nonstress test within a week. (p. 352-353)

15. A biophysical profile, nipple stimulation test and oxytocin challenge test should have been done at the time of the August 10, 1984 admission. (p. 179)

16. The care rendered to Patient A between August 10, 1984 and August 29, 1984 was not in accordance with the generally accepted standards of medical care. (p. 183)

CONCLUSIONS

With respect to Charge "A2", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Sustained by vote of 3-0.

Second Specification (Gross Negligence and/or Gross Incompetence) - Not sustained by vote of 3-0.

As above noted, the Hearing Committee concludes that this patient, who was over 40 weeks into her pregnancy and beyond, should be closely monitored and frequently tested to insure that

the fetus is in good health and condition. This was not done by Respondent.

FACTUAL ALLEGATIONS
Charge "A3"

> 3. On or about August 13, 1984, Respondent performed an x-ray of Patient A's abdomen to determine fetal position, thereby exposing Patient A and the fetus to unnecessary radiation.

FINDINGS

17. On August 13, 1984, Respondent performed an x-ray of Patient A's abdominal area at the Doctor's Clinic in Massena, New York. (Exh. "2")

18. The x-ray was done to determine fetal size and position. (Exh. "2")

19. Performing an x-ray on Patient A at this point in her pregnancy did not comport with general accepted medical standards. (p. 172)

20. The appropriate procedure would have been to obtain a biophysical profile sonogram to determine the size of the fetus, amount of amniotic fluid, appearance of the placenta, fetal motion and fetal breathing activity to assess the well-being of the infant. (p. 172-173)

21. Unnecessary exposure to radiation can harm the fetus. (p. 174)

CONCLUSIONS

With respect to charge "A3", the Hearing Committee concludes

as follows:

First Specification (Negligence and/or Incompetence)- Sustained by vote of 3-0.

Second Specification (Gross Negligence and/or Gross Incompetence) - Not sustained by vote of 3-0.

The Hearing Committee concludes that the use of an x-ray to evaluate Patient A's condition on August 13, 1984 was inappropriate and did not comport with the standards of good medical care. A sonogram would have been the appropriate procedure and would have provided the Respondent with the necessary information.

FACTUAL ALLEGATIONS
Charges "B1" and "B2"

B. On or about August 29, 1984, Patient A was admitted to Massena Memorial Hospital in Massena, New York for labor and delivery.

1. Respondent failed to recognize the risks associated with Patient A's postmature pregnancy.

2. Respondent failed to arrange for close monitoring of the fetal heart rate.

FINDINGS

22. Patient A was readmitted to Massena Memorial Hospital for delivery at approximately 11:30 a.m. on August 29, 1984. (Exh. "4")

23. Patient A had previously been admitted and scheduled for a "C" section that day, but due to lack of availability of the operating room, the procedure was cancelled. (p. 522-523)

24. Patient A was placed on an external fetal monitor from 1:05 p.m. to 1:40 p.m. (p. 42, 43, 50)

25. This fetal monitoring procedure was done for approximately one half hour in accordance with hospital policy. (p. 41, 68, 524) (Exh. "4")

26. Nurse West read the fetal monitoring strip. However, due to the fact that a portion of the strip was folded, Nurse West did not see a portion of the strip which indicated some deceleration. (p. 52)

27. Nurse West thereafter advised Respondent by telephone call that the strip showed little variability but nothing else remarkable. (p. 45, 47, 68)

28. Labor is a dangerous time for post-term fetus, and, therefore, it should be closely monitored. (p. 577, 578)

29. In a patient presenting, such as Patient A, continuous heart monitoring with a strip should be performed. (p. 188, 189, 433, 434, 579)

30. Continuous monitoring was not ordered by Respondent. (p. 580)

CONCLUSIONS

With respect to Charges "B1" and "B2", the Committee concludes as follows:

First Specification (Negligence and/or Incompetence)- Sustained by vote of 3-0.

Third Specification (Gross Negligence and/or Gross Incompetence) - Not sustained by vote of 3-0.

Nonstress tests were not given at appropriate intervals and with sufficient frequency. Nor did Respondent arrange for close monitoring of the fetal heart rate with a fetal strip. The Committee further concludes that Respondent did not recognize the risk associated with Patient A's post-term pregnancy.

FACTUAL ALLEGATIONS
Charge "B3"

3. Respondent failed to review the fetal monitor strip through the course of Patient A's labor.

FINDINGS

31. Respondent did not review the fetal monitoring strip, which was obtained by Nurse West. (p. 586-587)

32. Respondent had been advised by Nurse West via telephone that said monitoring strip showed nothing remarkable and little variability. (p. 45, 47, 68)

33. Upon Respondent's arrival at the hospital, he had a conversation with Nurse Miller during the course of which no information was given by Nurse Miller indicating that there was anything unusual in Patient A's labor or condition. (p. 526, 666-669)

CONCLUSIONS

With Respect to Charge "B3", the Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote (3-0).

Third Specification (Gross Negligence or Gross Incompetence) - Not sustained by vote (3-0).

The allegation that the Respondent failed to review the fetal monitoring strip is an accurate statement of fact, and Respondent admitted same on the record. Respondent further testified that the strip did not appear to be readily available. Although it would have been better practice for Respondent to have personally reviewed said strip, the Committee does not conclude that Respondent's reliance on the judgment of Nurse West and Nurse Miller rose to the level of misconduct.

FACTUAL ALLEGATIONS
Charge "B4"

> 4. Respondent prescribed 10 grains of quinine on at least two occasions during Patient A's labor despite its contraindication.

FINDINGS

34. On August 29, 1984, Respondent had quinine administered to Patient A on two occasions. (Exh. "4" - p. 55)

35. Quinine has been used successfully as a substance to initiate labor and has been used in the area that Respondent practiced. (p. 318, 320, 337)

36. Quinine is not contraindicated after labor commences. (p. 338)

CONCLUSIONS

With respect to Charge "B4", the Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote (3-0).

Third Specification (Gross Negligence or Gross Incompetence) - Not sustained by vote (3-0).

The record indicates that the current drug in accepted use to induce labor is Pitocin. (p. 192) However, the record indicates that Quinine has been used in the past. There is no evidence in the record to support the charge that Quinine was contraindicated, and the Hearing Committee concludes that its use under the circumstances existing did not constitute negligence or incompetence.

FACTUAL ALLEGATIONS
Charge "B5"

5. Respondent failed to diagnose Patient A's arrest of labor.

FINDINGS

37. Patient A was in her first pregnancy. (Exh. "4")

38. It is not clear on the record whether Patient A ever went into active labor. (p. 380)

39. If "A" was in labor, it was progressing slowly, typical of a first pregnancy. (p. 548)

40. The progress of labor in a first pregnancy can vary from the usual criteria. (p. 235)

CONCLUSIONS

With respect to Charge "B5", the Hearing Committee concludes

as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Third Specification - (Gross Negligence or Gross Incompetence) - Not sustained by vote of 3-0.

The Hearing Committee concludes that there is no clear proof establishing whether Patient A did, in fact, go into labor, and consequently, the charge assumes a fact not proven. Assuming that Patient A did start labor, the Respondent recognized that she needed something to enhance labor and administered Quinine.

FACTUAL ALLEGATIONS
Charge "B6(i)"

> 6. Respondent failed to recognize the emergency of fetal distress in Patient A in that:
>
> > (i) Respondent failed to respond to the significance of decreased variability of the fetal heart rate after little variability had been noted upon admission of Patient A.

FINDINGS

41. See above Findings "31", "32" and "33."

CONCLUSIONS

With respect to Charge "B6(i)", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote (3-0).

Third Specification (Gross Negligence or Gross Incompetence)

- Not sustained by vote (3-0).

The Hearing Committee has concluded that Respondent did not read the fetal monitoring strip produced by Nurse West when Patient "A" was first admitted to the hospital and that it was permissible under the circumstances to rely on Nurse West's evaluation. There were no other monitoring strips made thereafter (as the language of this charge seems to imply) which could be used to compare with the first strip to show "decreased variability." The language of this charge assumes a fact not proven, and the charge is not sustained.

FACTUAL ALLEGATIONS
Charge "B6(ii)"

> (ii) Respondent failed to initiate prompt diagnostic measures and appropriate treatment when advised no fetal heart could be heard.

FINDINGS

42. There appear to be confusing and conflicting entries in Exhibit "4", the hospital record of Patient A. It is not clear when Respondent was first telephoned by Nurse Miller and advised that a fetal heartbeat could not be detected. Said call could have been made from 10:30 to 10:55 p.m. (Exh. "4" - p. 55, 56) (p. 527, 661)

43. When Respondent first received said call, he advised Nurse Miller to continue to check and call him back. (p. 661)

44. It is not clear when Nurse Miller called Respondent

back a second time. (Exh. "4")

45. When Respondent received the second call, he instructed Nurse Miller to call Dr. Choi in on consultation. (Exh. "4" - p. 55-56) (p. 528, 662)

46. Respondent and Dr. Choi both arrived at the hospital at some time between 11:20 and 11:45 p.m. (Exh. "4" - p. 56)

CONCLUSIONS

With respect to Charge "B6(ii)", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Third Specification (Gross Negligence or Gross Incompetence) - Not Sustained by vote of 3-0.

Respondent is accused of failing to act promptly. It is, therefore, directly relevant as to when Respondent first received the telephone calls advising him of the absence of a fetal heartbeat. Both the testimony and patient records are confusing and unclear. There is nothing in the record necessarily inconsistent with Respondent's assertions that he was at the hospital within 20 minutes after the second phone call from Nurse Miller.

FACTUAL ALLEGATIONS

Charge "B7(i)"

7. Respondent failed to maintain accurate medical records in that:

(i) Respondent's records disclose Patient A's labor as uncomplicated and that "labor progressed well" when in fact the labor had arrested.

FINDINGS

47. Respondent's entries in Patient A's discharge summary at the hospital stated, in part, that labor progressed "well." (Exh. "4" - p. 2)

48. Respondent also made entries in patient's records that "her labor appears to be uncomplicated." (Exh. "4" - p. 3)

CONCLUSIONS

With respect to Charge "B7(i)" the Hearing Committee concludes as follows:

Fifth Specification (Practicing the Profession Fraudulently) - Not sustained by vote of 3-0.

Ninth Specification (Committing Unprofessional Conduct by Failing to Maintain Accurate Patient Record) - Not sustained by vote of 3-0.

The factual allegation, as stated in the Statement of Charges, is a correct one. The Respondent did, in fact, note that labor progressed well. However, the Hearing Committee does not conclude Respondent made those entries fraudulently and with intent to deceive or misrepresent. The Committee concludes that Respondent was not, in fact, aware of a problem with Patient A's pregnancy until he subsequently learned of the absence of a fetal heartbeat. Whether Respondent should have been aware of the

medical problem is moot to this charge and has been addressed elsewhere in this report.

FACTUAL ALLEGATIONS
Charge "B7(ii)"

> (ii) Respondent's records fail to disclose a 10:35 p.m. call made to Respondent advising no fetal heart could be heard.

FINDINGS

49. Respondent wrote a discharge summary in Patient A's records, which contained the statement that "...at 11:35 p.m. a call was received from the nurse to alert us that there was difficulty hearing a fetal heart..." (Exh. "4")

50. Respondent dictated his discharge summary subsequent to September 8, 1984. (p. 558-559)

CONCLUSIONS

With respect to Charge "B7(ii)", the Hearing Committee concludes as follows:

Sixth Specification (Practicing the Profession Fraudulently) - Not sustained by vote of 3-0.

Tenth Specification (Committing Unprofessional Conduct by Failing to Maintain Accurate Patient Record) - Not sustained by vote of 3-0.

The Respondent is charged with fraud by reason of an entry in the record relative to the time a telephone call was allegedly made. It is clear that Respondent did note the telephone call but indicated that it was made at 11:35 p.m., not at 10:35 p.m.,

as alleged in the Charges.

This discharge summary was made by Respondent one to two weeks after August 29, 1984, which was the date of the call. The records pertaining to these calls are confusing, and under the circumstances, the entries made by Respondent can reasonably be attributed to confusion in the records rather than fraudulent intent.

FACTUAL ALLEGATIONS
Charges "C1" and "C2"

C. On or about July 5, 1985, Respondent provided care and treatment to Patient B when Patient B was admitted to Massena Memorial Hospital in Massena, New York, for labor and delivery.

1. Respondent failed to record adequately Patient B's labor.

2. Respondent failed to record an adequate medical history in Patient B's hospital record.

FINDINGS

51. Patient B was admitted to Massena Memorial Hospital on July 5, 1985 for delivery of a full-term fetus. (Exh. "7")

52. Respondent noted in the delivery record that presentation was occiput (vertex) position. (Exh. "7" - p. 4, 36) (p. 442)

53. The general progress of "B"'s labor and frequency of contractions were also recorded in the hospital-labor record as well as other relevant factors. (Exh. "7" - p. 4, 5, 6, 36-37)

54. The medical history and progress of labor were adequately reported in Patient B's hospital record. (p. 442)

55. With respect to past history, patient's chart shows medical history, including first pregnancy, expected date of confinement and last menstrual period. (Exh. "7" - p. 4, 5, 7, 34, 36)

CONCLUSIONS

With respect to Charge "C1", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Eleventh Specification (Committing Unprofessional Conduct by Failing to Maintain Accurate Patient Record) - Not sustained by vote of 3-0.

With respect to Charge "C2", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not Sustained by vote of 3-0.

Twelfth Specification (Committing Unprofessional Conduct by Failing to Maintain Accurate Patient Record) - Not sustained by vote of 3-0.

Patient B had a normal, uneventful birth. Patient records showed medical history, presentation of the fetus and the monitoring of the progress of labor. Respondent's expert acknowledged in his testimony that the record ideally could have been more detailed. However, the Committee concludes that the records were adequate and accurate, and any omissions did not constitute misconduct.

FACTUAL ALLEGATIONS
Charge "C3(i)(ii)"

3. Respondent failed to recognize the emergency of fetal distress in Patient B in that:

(i) Respondent failed to respond adequately to the lack of fetal heart rate variability during the course of Patient B's labor.

(ii) Respondent failed to respond adequately to patterns of late deceleration of the fetal heart rate during the course of Patient B's labor.

FINDINGS

56. Electrodes were put in place to monitor Patient B's fetus. (Exh. "7" - p. 7)

57. The monitor strip shows some widely spaced and brief periods of deceleration but overall did not support a diagnosis that the fetus was in distress. (p. 282, 449, 451-452)

58. There were no clear patterns of deceleration. (p. 445-450)

59. No fetal distress having been evidenced, there was no emergency with respect to the delivery of Patient B. (p. 450)

60. Patient B's baby had an apgar of six and nine, which were indicative of a healthy infant. (p. 450)

CONCLUSIONS

With respect to Charges "C3(i)" and "C3(ii)", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not

Sustained by vote of 3-0.

Fourth Specification (Gross Negligence or Gross Incompetence) - Not sustained by vote of 3-0.

The language of the allegations is not supported by the record. Respondent is charged with "not responding adequately" to lack of fetal heart rate variability. The Committee concluded that the lack of variability was widely spaced, intermittent, transient and was relatively insignificant. Having concluded that there were no "patterns" of deceleration, obviously there was no response necessary or appropriate.

FACTUAL ALLEGATIONS
Charge "C4"

> 4. Respondent prescribed 10 grains quinine on at least two occasions during Patient B's labor despite its contraindication.

FINDINGS

61. During the course of Patient B's labor, Respondent ordered quinine on two occasions, 4:15 p.m. and 9:00 p.m., on July 5, 1985. (Exh. "7")

62. Quinine has been used an oxytocic agent to initiate and induce labor. (p. 319, 322, 483)

63. There are occasions when it may not be effective, but it would not necessarily be contraindicated. (p. 321, 337)

64. Pitocin is currently the drug of choice for inducing labor. (p. 192)

CONCLUSIONS

With respect to Charge "C4", the Hearing Committee concludes as follows:

First Specification - (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Fourth Specification - (Gross Negligence or Gross Incompetence) - Not sustained by vote of 3-0.

Although the record would indicate that the use of Quinine may be somewhat outmoded and that generally Pitocin is used as a labor-inducing drug, there is nothing to support the charge that quinine was contraindicated. It apparently has been used in the past with some degree of success. There is nothing in the record to sustain a conclusion that at the time and place given it was harmful or potentially harmful to the patient.

FACTUAL ALLEGATIONS
Charges "C5(i)(ii)(iii)(iv)"

5. Respondent failed to follow the recommendations of a consulting physician, to wit:

(i) Respondent failed to obtain a urinalysis.

This charge was withdrawn.

(ii) Respondent failed to obtain a complete blood count.

This charge was withdrawn.

(iii) Respondent failed to conduct a pelvinimetry of Patient B.

This charge was withdrawn.

(iv) Respondent failed to augment Patient B"s contractions with Pitocin.

FINDINGS

65. Respondent consulted with a Dr. Choi, an obstetrician, at 4:00 p.m. on July 5, 1985. Dr. Choi recommended the use of Pitocin to augment labor. (Exh. "7" - p. 7)

66. Respondent did not follow said recommendation and did not employ the use of Pitocin. (Exh. "7")

67. The use of Pitocin should be done as a last resort, and Respondent's withholding the use of Pitocin under these circumstances was appropriate. (p. 321-322, 336, 483, 485)

CONCLUSIONS

With respect to Charge "C5(iv)", the Hearing Committee concludes as follows:

First Specification (Negligence and/or Incompetence) - Not sustained by vote of 3-0.

Fourth Specification (Gross Negligence or Gross Incompetence) - Not sustained by vote of 3-0.

Even though it is acknowledged that Dr. Choi did make an entry in the patient chart recommending Pitocin by drip to induce labor, there was nothing in the record that Respondent's failure or refusal to do so constituted negligence, incompetence or misconduct of any kind. To the contrary, all of the expert testimony offered by both Petitioner and Respondent would indicate that at the time and place Pitocin was contraindicated

and would expose Patient B, who was in her first pregnancy, to unnecessary additional risk.

SUMMARY OF CONCLUSIONS

As hereinbefore set forth under Conclusions, the Committee has found that the following charges were sustained by the Department:

Charge "A1(i)" - Seventh Specification
Charge "A2" - First Specification
Charge "A3" - First Specification
Charge "B1" - First Specification
Charge "B2" - First Specification

RECOMMENDATIONS

The Hearing Committee has sustained five of the charges. On several other charges the Hearing Committee has given the Respondent the benefit of any doubt with respect to the issue of misconduct. However, it is the consensus of the Committee that overall the Respondent has demonstrated deficient skills in the field of obstetrics.

The Hearing Committee recommends:

a. Censure and reprimand;

b. That the necessary steps be taken so that Respondent is

hereafter prohibited from engaging in any practice in the field of obstetrics.

DATED: March 7, 1989

Respectfully submitted,

JOHN T. PRIOR, M.D.,
Chairperson
Reverend Edward J. Hayes
Therese G. Lynch, M.D.

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	
OF	:	COMMISSIONER'S
HENRY J. DOBIES, M.D.	:	RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on July 14, August 18, August 19, October 28 and November 11, 1988. Respondent, Henry J. Dobies, M.D., appeared by Wood & Scher, Esqs., Anthony Z. Scher, Esq., of Counsel. The evidence in support of the charges against the Respondent was presented by Daniel J. Persing, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted except as follows:

1. I agree with the Committee's findings and conclusions with regard to negligence. However, I would sustain the Second Specification (gross negligence) with respect to charges A(2) and A(3). Respondent allowed an overterm patient to go 18 days without a non-stress test and performed an x-ray of the patient during that 18-day period. In my view, both constitute a reckless indifference to the health of the mother and the fetus.

2. I agree with the Committee's finding with regard to charge B(3) but not its conclusion. Respondent had a clear obligation to review the fetal monitoring strip and not to rely on a nurse's characterization of what it showed. This was negligence.

3. I also disagree with the Committee's conclusion with regard to charges B(3) and C(4). The Committee notes that Pitocin is the drug of choice to induce labor and that Quinine may be outmoded. While one elderly physician may have used Quinine in the Massena area, it is not generally accepted standard practice. Respondent's use of Quinine was negligence.

4. I also disagree with the Committee's conclusion regarding charge B(6)(i). Respondent negligently failed to respond to the fact that there was little variability as Respondent was advised (Finding of Fact #27). This should have alerted Respondent to the fact that the fetus was in distress.

B. The Recommendation of the Committee should be modified as follows. Respondent's license to practice medicine should be suspended so that he is not allowed to practice obstetrics except to take a retraining course on obstetrics of at least six months duration approved in advance by the Office of Professional Medical Conduct. Upon Respondent's successful completion of such retraining, as certified by OPMC, the suspension of Respondent's license to practice should be continued for three additional years and such suspension stayed provided that during such period Respondent' obstetrical practice should be monitored by an obstetrician approved by OPMC. The monitor shall submit quarterly reports to OPMC

as to the propriety of Respondent's obstetrical practice.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as modified above.

The entire record of the within proceeding is transmitted with this Recommendation.

Dated: Albany, New York
May 18 1989

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

HENRY J. DOBIES

CALENDAR NO. 10113

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

   b. That, during the period of probation, respondent is prohibited from and is not practicing in the area of obstetrics unless and until respondent takes and successfully completes a one year course of training in obstetrics, said course to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   c. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   d. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;

   e. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That upon respondent's successful completion of a one year course of training in obstetrics, written proof of which must be provided to the Director of the Office of Professional Medical Conduct within seven days of such successful completion, then, should any period of probation still remain, respondent shall have his practice monitored, at respondent's expense, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct; and

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records and hospital charts in regard to respondent's practice of obstetrics, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   c. That said monitor shall submit a report, once every four months, or as otherwise determined by the Director of the Office of Professional Medical Conduct, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct.

3. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding.

ORDER OF THE COMMISSIONER OF EDUCATION OF THE STATE OF NEW YORK

HENRY J. DOBIES

CALENDAR NO. 10113

The University of the State of New York

IN THE MATTER

OF

HENRY J. DOBIES
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10113

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10113, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (February 16, 1990): That, in the matter of HENRY J. DOBIES, respondent, the recommendation of the Regents Review Committee be accepted as to the findings of fact and conclusions as follows and its recommendation as to the measure of discipline be modified as follows:

1. The hearing committee's findings of fact be accepted, and the Commissioner of Health's recommendation as to the hearing committee's findings of fact be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted as hereafter indicated, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted to the extent hereafter indicated;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
4. Respondent be found guilty, by a preponderance of the evidence, of paragraphs A(2), A(3), B(1), and B(2) under

the first specification of the statement of charges as constituting negligence on more than one occasion, and of the seventh specification of the charges, and not guilty of the remaining charges; and

5. In partial agreement with the Commissioner of Health, and recognizing the concerns reflected by the penalty recommended by the Commissioner of Health and, accordingly, feeling it more appropriate to impose a prohibition of practice as a partial suspension than as a term of probation as suggested by the Regents Review Committee, respondent's license to practice as a physician in the State of New York be concurrently suspended, upon each specification of the charges of which respondent was found guilty, in the area of obstetrics until respondent successfully completes, at respondent's expense, a course of retraining in the area of obstetrics, said course to be selected by respondent and previously approved, in writing, by the Executive Director of the Office of Professional Discipline of the New York State Education Department, written proof of the successful completion of said course to be submitted to the satisfaction of said Executive Director within 10 days of such successful completion;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of

the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 22nd day of February 1990.

Thomas Sobol

Commissioner of Education